

2009 Enrollment Application Instructions -- PAGE 1
KENTUCKY TEACHERS' RETIREMENT SYSTEM

Reason for Application

- **New Retiree:** Check this box if you are a new retiree of the Kentucky Teachers' Retirement System.
- **Open Enrollment:** Check this box if you are filling out this application due to Open Enrollment.
- **QE:** Check this box if you are making a change to your coverage Option, as permitted by a valid QE.
- **Previously Waived (i.e. decline):** Check this box if you previously waived (i.e. decline) your health insurance coverage and have now experienced a qualifying event that allows you to select health insurance coverage. You must provide the date and description of the qualifying event in the spaces provided below. All other qualifying events do not require an application and do require an ADD or DROP Form Only. You may request an ADD or DROP Form from your Insurance Coordinator and must provide supporting documentation, as required.
- **Other:** Check this box if none of the listed options apply. The Insurance Coordinator must provide a date and an explanation if "Other" is selected.

NOTE TO THE INSURANCE COORDINATOR: Complete the information requested within the box in the top right hand corner of the application.

- Enter the effective date of coverage.

SECTION I: DEMOGRAPHIC INFORMATION – Please PRINT clearly.

- If you are not the retiree and you are applying for health insurance coverage, enter your relationship to the retiree (SP = Spouse or CH = Child).
- **RETIREE:** If you are the retiree, enter your Social Security Number and your name (First, MI, Last) and go to *Applicant Specific Information* below.
- **APPLICANT:** If you are not the retiree:
 - Enter the retiree's Social Security Number and the retiree's name (First, MI, Last) in the space labeled *Retiree* above.
 - Enter your Social Security Number and your name (First, MI, Last) under *Applicant*.
 - Go to *Applicant Specific Information*.
- **RETIREE AND/OR APPLICANT Specific Information:**
 - Enter the Planholder's Address (including County of Residence), Date of Birth, Home and Cell Phone Number, email address if available, Smoking Status, Gender and Marital Status in this section.

Note: If the smoking status flag is not checked, this application will be pended until the information is provided.

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SECTION II: PLAN ELECTION – *If waiving (i.e. decline) health insurance coverage, go to Section V.*

1. **Option:** Mark the box that indicates the option you are electing. For a description of each option, see the Health Insurance Handbook. **Elect only one.**
2. **Level of Coverage:** Mark the box that indicates the level of coverage you are electing. For a description of each level of coverage, see the Health Insurance Handbook. **Elect only one.**
3. **Cross-reference:** If you wish to pay by cross-reference, mark this box and complete sections III, IV and VII. If you wish to pay by cross-reference, **ONLY ONE** application is required.

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION

Complete this section only if you are covering your eligible **spouse, dependent child(ren)** or have chosen the **cross-reference payment option** on your health insurance plan. Enter the required information for each dependent that you wish to cover. If you need additional space, use Page 1 of another Enrollment Application. Do not complete this section if you are electing Single coverage.

Relationship Code: Enter the appropriate relationship code as follows:

- **SP** Spouse (your eligible spouse).
- **CH** Child (your eligible child, step child, adopted child, foster child or your grandchild that is considered your dependent and who is not disabled) age 0-25.
- **DD** Disabled Dependent Child (your eligible disabled child). If your disabled dependent child is 25 years old or older, your health insurance carrier will request evidence of his/her disability annually.
- **CO** Court Ordered Dependent Child (an eligible dependent child that you are court ordered to carry on your health insurance or an eligible dependent child of whom you have full guardianship).

SECTION IV: SPOUSE'S CROSS-REFERENCE INFORMATION

Complete this section **ONLY** if you and your spouse are electing to pay by cross-reference.

- Enter your spouse's company number. **Required.**
- Enter your spouse's dual employee indicator if applicable.
- Enter your spouse's smoking status. **Required.**
- Enter whether or not your spouse is a hazardous duty retiree.
- Enter your spouse's hire date or retirement date, if applicable. This field is needed if the planholder elects to start a cross-reference payment method when his/her spouse becomes employed or newly retired with an agency that participates in the Kentucky Employee's Health Plan.
- Enter your spouse's deduction start date. This field is only needed if the policyholder elects to start a cross-reference payment method with a Board of Education employee.

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Enter the social security number of the retiree in the spaces provided on the top left hand corner of Page 2. Enter the social security number of the planholder (and applicant if applicable) in the spaces provided on the top right hand corner of Page 2.

SECTION V: WAIVING (i.e. decline) HEALTH INSURANCE COVERAGE

Check this box if you choose to waive (i.e. decline) health insurance coverage with your retirement system.

SECTION VI: NOT APPLICABLE

NOTE: If a retiree elects to pay by cross-reference with an active spouse and the active spouse is eligible and would like to enroll in the state's Flexible Spending Account Program, the active spouse and the retiree should make their health coverage elections by completing the active spouse's Enrollment Application.

SECTION VII: AUTHORIZATION AND CERTIFICATION

Read the statements in this section carefully. After you have read and understood the statements, sign your name on the "Retiree Signature or Applicant Signature" line and enter today's date in the line provided.

If **you/planholder #1** are applying to pay by **cross-reference**, your **spouse/planholder #2** **MUST also sign** the application on the "Spouse Signature" line. He/she **must also enter today's date** in the line provided.

Your cross-referenced spouse/planholder #2 must have his/her Insurance Coordinator sign this form before you return it to your Insurance Coordinator.

Your **cross-reference application** will not be processed without the **four required signatures and dates**: planholder #1, planholder #2, and both Insurance Coordinators.

GENERAL REMINDERS:

Do not hold your application until the end of open enrollment. Return your application to your retirement system as soon as possible.

If you are planning to elect the cross-reference payment option, it is very important that you start the application process as early as possible. Again, your cross-reference application requires only one application with four different signatures.

Additional copies of the completed application may need to be made if paying by cross-reference to ensure that all parties maintain a copy for their records.